MASSACHUSETTS
HEALTH POLICY COMMISSION

2019 ANNUAL HEALTH CARE COST TRENDS REPORT
EXECUTIVE SUMMARY

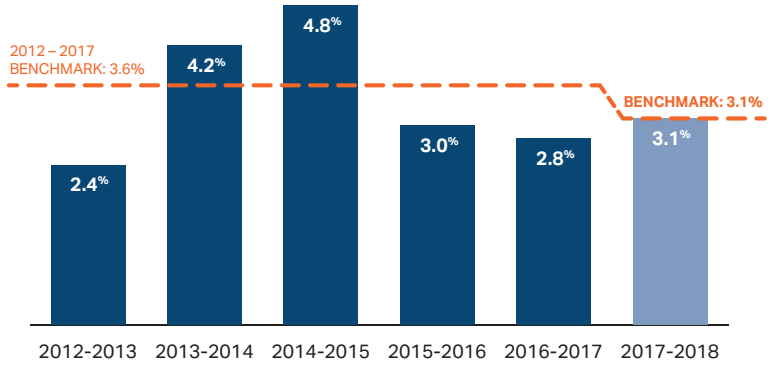
INTRODUCTION

While Massachusetts has a long history as a leading state for health care access and innovation, the affordability of the state's overall high-quality health care continues to be a challenge. In an effort to restrain rapidly increasing health care costs, comprehensive health care reform legislation passed in 2012 set a first-in-the-nation statewide target for sustainable growth in total health care spending (3.6 percent) and established the independent Massachusetts Health Policy Commission (HPC) to help monitor and guide this ambitious effort. Seven years later, the HPC has reported meaningful progress towards health care cost containment in the Commonwealth. Overall, since the benchmark was established, the state's health care spending has grown at a below-the-benchmark average annual rate of 3.4 percent. Most recently, from 2017 to 2018, the state's preliminary health care spending growth was 3.1 percent, equaling the newly lowered benchmark target for 2018 (**Exhibit 1**). Massachusetts total health care spending growth (including both public and private payers) has been below national growth rates for the ninth consecutive year, a reversal from previous trends.

In this annual report, the HPC presents new research to further enhance the collective understanding of health care spending trends and cost drivers in the Commonwealth, and evaluates the state's progress in meeting several cost containment, care delivery, and payment system goals set by the Commonwealth and the HPC. The report examines the market dynamics and spending drivers in two areas of particular interest: hospital inpatient and hospital outpatient services. These were two of the fastest growing health care spending categories from 2017 to 2018 (3.7 percent and 3.8 percent, respectively) and together account for over 40% of all health care spending in Massachusetts. Based on this analysis and other HPC research and programs, the report also includes a set of recommendations for policymakers as well as providers, payers, employers, patients, and other health care market participants who work collaboratively toward a more high-value system.

By many important indicators, Massachusetts has a high performing health care system. As the forerunner to the federal Patient Protection and Affordable Care Act (ACA), the state has the lowest rate of uninsured residents in the U.S. This year, Massachusetts ranked first in the Commonwealth Fund's scorecard on state health system performance in the categories of access and prevention and treatment. The United Health Foundation, a nationally recognized organization dedicated to improving health and health care, ranked Massachusetts as the second healthiest state in the country. Massachusetts is home to many renowned health care institutions that positively contribute to health care research and education for the entire world. The state's thriving life sciences industry generates foundational scientific advances leading to drugs and treatments that improve and save lives.

Exhibit 1 Annual growth in total health care expenditures per capita in Massachusetts



Notes: 2017-2018 spending growth is preliminary.

Sources: Center for Health Information and Analysis Annual Report, 2019

However, there are a number of metrics of health system performance in which Massachusetts trails the country. Emergency department, hospital outpatient, and acute care hospital use in Massachusetts are above national averages, and the hospital readmissions rate in Massachusetts is higher than nearly every state in the U.S. The Commonwealth Fund's scorecard ranked Massachusetts 31st in the nation for avoidable hospital use and costs, while the United Health Foundation ranked Massachusetts 37th in preventable hospitalizations.

Massachusetts also faces continued health equity challenges. As detailed in the Department of Public Health's *2017 Massachusetts State Health Assessment*, persistent disparities in health outcomes remain among low-income communities, people of color, LGBTQ+ individuals, and other populations, despite Massachusetts' long-standing commitments to inclusive health care reform and access to care.

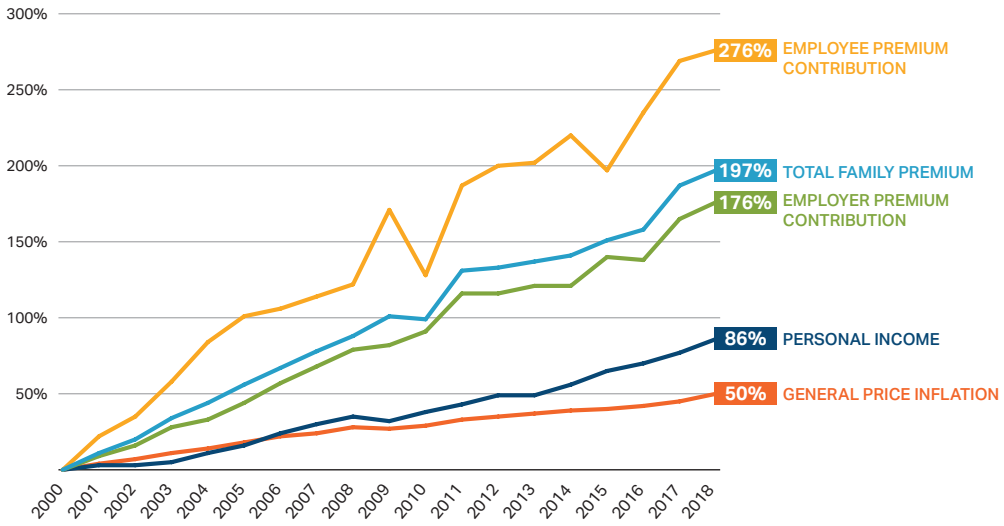
Health care affordability is also a significant and growing challenge. Premium growth has far outpaced general price inflation, with employees paying an increasing share. Between 2000 and 2018 in Massachusetts, the consumer price index grew by 50 percent, while the average cost for a family premium nearly tripled, from $7,341 to $21,801 (**Exhibit 2**). Employees' direct premium contributions rose even faster (by a factor of nearly four) as employees paid an increasingly larger share of premiums over this time period out of their paychecks (increasing from 21 percent of the premium being paid by employees to 26 percent). Cost-sharing has risen even faster than premium growth in the past several years, and nearly one-third of privately insured Massachusetts residents now have high-deductible health plans.

The growth in health care costs results in difficult financial choices for many families. In 2017, one in four Massachusetts residents reported having gone without needed medical or dental care due to cost, and 17 percent reported having family medical debt. In 2019, one in four Massachusetts residents reported forgoing medically necessary prescription drugs, resulting in difficult choices (rationing or cutting pills) and ultimately worsening health for many residents.

Nonetheless, despite considerable and persistent cost and equity challenges, Massachusetts is uniquely positioned to continue to lead the nation in advancing a high performing, high value, and affordable health care system. Inspired by the success of Massachusetts, a number of states around the country have recently established health care cost containment goals and monitoring government agencies. In early 2020, the Altarum Healthcare Value Hub ranked states on their efforts to improve health care affordability, citing Massachusetts as first in the nation for its efforts to date.

As evidenced by the findings contained in this report and other HPC research, it is clear that further policy action and a redoubled commitment from health care market participants is needed to realize this promise for the next decade. The HPC stands ready to support these efforts with data insights and independent policy leadership.

Exhibit 2 Growth of premiums, income, and inflation in Massachusetts, 2000 – 2018



Notes: Total family premium includes the portion of the premium paid by employees and the part paid by the employer. Personal income refers to income per capita in Massachusetts. General inflation refers to changes in the Consumer Price Index (CPI-U).

Sources: HPC analysis of Medical Expenditure Panel Survey (MEPS), Bureau of Labor Statistics (BLS), and Federal Reserve data, 2000-2018.

KEY FINDINGS

TRENDS IN SPENDING AND CARE DELIVERY

3.1%

Health care spending growth in Massachusetts in 2018 exactly matched the benchmark rate (3.1 percent) and was below the national trend for the 9th consecutive year.

Spending growth per enrollee varied by sector with both commercial (4.6 percent) and Medicare FFS (3.9 percent) exceeding the benchmark, and MassHealth below (2.6 percent).

$

Employee premium contributions for family coverage for workers in low-wage firms have risen rapidly in recent years and now exceed $8,000 per year ($683 per month) on average, higher than for other workers (less than $6,000 per year, or $500 monthly).

40¢

Health care spending growth in Massachusetts between 2016 and 2018 absorbed almost 40 cents of every additional dollar earned for families with coverage through employers, more than they took home in pay after taxes.

HOSPITAL INPATIENT SPENDING AND UTILIZATION

5.2%

Hospital inpatient spending has continued to grow despite a constant or declining number of hospital stays; among commercially-insured patients, spending per inpatient stay grew 5.2 percent annually between 2013 and 2018, from $14,500 to $18,700.

One factor leading to higher spending per stay is increasing acuity among inpatient stays. Acuity grew by more than 10 percent from 2013 to 2018 for all hospitalized patients; patient risk scores grew by 11.7 percent over this period.

Factors such as population aging, changes in underlying disease prevalence or health status, or shifting of healthier patients out of hospital settings do not explain growing patient acuity or risk scores. Evidence suggests that a considerable portion of the change is due to hospital coding practices.

9.3%

Commercial inpatient volume declined 9.3 percent between 2014 and 2018.

The decline in inpatient hospital stays was almost entirely due to fewer maternity-related discharges and fewer scheduled admissions, as opposed to admissions from the emergency department.

HOSPITAL OUTPATIENT SPENDING GROWTH

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Hospital outpatient spending accounts for 60 percent of hospital spending for commercially-insured residents, with outpatient surgery accounting for more than a third of hospital outpatient spending. Spending in this subcategory grew 11 percent from 2015 to 2017.

Among outpatient surgery episodes, spending on major surgery grew 9.5 percent from 2015 to 2017, driven by a 10.2 percent increase in hospital payments per episode.

2x

Among the six highest-volume hospitals, payments per major outpatient surgery episode were nearly twice as high at Massachusetts General Hospital and Brigham and Women's Hospital as the lowest-paid high-volume hospital.

Shifting of hysterectomy from inpatient to outpatient settings would save money, yet savings are eroded by price increases in both settings and a shifting of surgery cases from low-cost hospitals to high-cost hospitals.

2019 SUMMARY POLICY RECOMMENDATIONS

The HPC issued fifteen recommendations to advance Massachusetts' cost containment goals and improve health care in the Commonwealth. These recommendations require action by health insurers, providers, employers, policymakers, and other state agencies to advance the goal of a more transparent, accountable, and innovative health care system in Massachusetts. Please see **Chapter 5** of the report for the full text of the recommendations and a summary may be found below:

NEW **1. PRIMARY AND BEHAVIORAL HEALTH CARE. Payers and providers should increase spending devoted to primary care and behavioral health while adhering to the cost growth benchmark.** Policymakers, payers, and providers should support advancements to develop and utilize technology, such as telehealth, that improves access to primary and behavioral health care. Lawmakers should amend scope of practice laws that are not evidence-based and should continue to strengthen the health care workforce with roles designed to meet the needs of the communities and patient populations they serve.

NEW **2. AMBULATORY CARE. The Commonwealth should closely scrutinize how care is delivered and paid for in different ambulatory settings, including urgent care and hospital main campus and off-campus sites.** Regulators, payers, and other stakeholders should also examine provider plans for outpatient service expansions and critically consider how new projects are likely to impact cost, quality, access, and competition in the provider market.

NEW **3. CODING INTENSITY. The Commonwealth should take action to mitigate impacts of improved clinical documentation on spending and performance measurement.** Specific areas of action include more frequent updates to software programs to better align payments with actual resource use, mechanisms to offset coding-related spending impacts, and continued development of alternative risk adjustment methods and performance metrics less sensitive to coding-based acuity.

NEW **4. PHARMACEUTICAL SPENDING. The Commonwealth should take action to reduce drug spending growth and implement policies to increase oversight and transparency for the full drug distribution train, such as by authorizing the expansion of the HPC's review to include drugs with a financial impact on the commercial market in Massachusetts and increasing state oversight of pharmacy benefit managers' (PBMs) pricing practices.** Payers and providers should pursue strategies to maximize value and enhance access by using risk-based contracts and value-based benchmarks when negotiating prices, distributing clinical decision tools, monitoring prescribing patterns, and developing plan designs that minimize financial barriers to high-value drugs.

NEW **5. ACCOUNTABILITY UNDER THE COST GROWTH BENCHMARK. The Commonwealth should strengthen its ability to hold health care entities responsible for their spending growth.** Policymakers should improve the annual performance improvement plan (PIP) process by allowing the Center for Health Information and Analysis (CHIA) to use metrics beyond health status adjusted total medical expenses when identifying entities and strengthen the HPC's ability to hold entities accountable for spending that impacts the health care cost growth benchmark by enhancing financial penalties for above-benchmark performance and non-compliance.

NEW **6. EMPLOYER ENGAGEMENT AND CONSUMER CHOICE. The Massachusetts business community should increase its coordinated engagement to drive changes in health care.** Employers should collaborate with payers, providers, and other stakeholders to influence changes in spending and affordability, care delivery, and the promotion of a value-based market. Specific levers include lowering premium contributions for plans favoring efficient providers, promoting the use of two-sided risk contracts, and offering coverage through Health Connector for Business if eligible. To further support these strategies, policymakers should take action to broaden employer access to a wide range of insurance products for their employees and to ensure that payers make affordable, high-value products available.

7. ADMINISTRATIVE COMPLEXITY. The Commonwealth should take action to identify and address areas of administrative complexity that add cost to the health care system without improving the value of care. Specific areas of focus should include requiring greater standardization of common administrative tasks across payers and facilitating efforts between government, payers, providers, and patients to identify and reduce other drivers of valueless administrative complexity.

8. FACILITY FEES. Policymakers should take action to require site-neutral payment for common ambulatory services and limit the cases in which both newly licensed and existing sites can bill as hospital outpatient departments. Additionally, outpatient sites that charge facility fees should be required to conspicuously and clearly disclose this fact to patients, prior to delivering care.

9. OUT-OF-NETWORK BILLING. Policymakers should enact a comprehensive law to address out-of-network billing. Specific provisions should include requirements for advance patient notification when a provider may be out-of-network, protections for consumers from out-of-network bills in emergency and "surprise" billing scenarios, and the establishment of a reasonable and fair reimbursement rate for out-of-network services through a statutory or regulatory process. Any such process should avoid using provider charges or list prices as a benchmark in determining payment.

10. ALTERNATIVE PAYMENT METHODS. The Commonwealth should continue to promote the increased adoption and effectiveness of APMs, especially in the commercial market where expansion has stalled. Specific areas of focus should include increased use of APMs for preferred provider organization (PPO) populations, alignment across payers and improvement of APM features including shifting to two-sided risk models, and adoption of bundled payments for common and costly episodes of care by payers and providers.

11. HEALTH DISPARITIES. The Commonwealth should seek to understand and address inequities in the opportunities and resources available to enable health and well-being for all citizens. Specific areas of focus should include policies to encourage downstream collaborations between health care providers and social service organizations to identify and address patients' health-related social needs (HRSN), and promotion of upstream cross-sector collaborations to understand the causes of health inequity in communities and leverage resources to address those inequities.

12. INVESTING IN INNOVATION, LEARNING, AND DISSEMINATION. The Commonwealth should continue to support targeted investments to promote innovation, learning, and dissemination of promising care models. Specific opportunities for investment include longitudinal care models to support individuals and families experiencing the effects of substance use disorder, alternatives to traditional hospital-based clinical care, telehealth as a strategy to increase access to high-need services such as behavioral health, care models that promote care coordination and integration, and maternal health—particularly among populations for which there are significant disparities in outcomes.

13. LOW VALUE CARE. The Commonwealth should act to reduce the provision of health care that does not provide value to patients. Payers, providers, and purchasers should collaborate on strategies to reduce low value care through measurement, reporting, and appropriate financial incentives and support the incorporation of evidence-based guidelines into practice. The Commonwealth should encourage information campaigns like Choosing Wisely® that disseminate research findings about low-value care to engage patients in their care and ensure they are informed about clinical value before they seek services.

14. PROVIDER PRICE VARIATION. The Commonwealth should take action to reduce unwarranted variation in provider prices. Policymakers should advance specific, data-driven interventions to address the pressing issue of persistent provider price variation, particularly given new findings indicating that savings from shifts from inpatient to outpatient care may be lost due to hospital price differentials.

15. AFFORDABILITY. Health care affordability must remain a central focus of the Commonwealth's health care agenda. The Commonwealth should continue to examine and address the factors impacting premium and out-of-pocket cost growth and their disproportionate impact on lower-to-middle income residents and small businesses.

The Massachusetts Health Policy Commission (HPC), established in 2012, is an independent state agency charged with monitoring health care spending growth in Massachusetts and providing data-driven policy recommendations regarding health care delivery and payment system reform. The HPC's mission is to advance a more transparent, accountable, and innovative health care system through independent policy leadership and innovative investment programs.

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